



## How To Write A Progress Note For A Scheduled Service

**Note: to document a progress note for a group, see How do I write a group progress note?**

1. On your Appointments for Today widget, click on the time link for the service you're documenting.

Appointments For Today <span>1</span> 		
Client Name/Description	Time	Status
<a href="#">Test, Name(Alcohol...</a>	<a href="#">01:00 PM</a>	Scheduled



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2. This opens the service note. Complete the service details.
  - a. Confirm/Enter Mode of Delivery.
  - b. Enter Face to Face Time. Under CalAIM Payment Reform, this is what is used for billing. Enter Travel Time and Documentation Time if applicable.
  - c. Enter Evidenced-Based Practices if applicable.

Service	
Status	Show
Program	Outpatient MH Adult
Procedure	Targeted Case Management
Location	Office
Clinician	Clinician, Robert
Mode Of Delivery	Face-to-face
Cancel Reason	
Evidence Based Practices	
Start Date	01/23/2023
Start Time	8:00 AM
Travel Time	20 Minutes
Documentation Time	10 Minutes
Face to Face Time	60 Minutes
Attending	
Referring	



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- d. If this is a note for a crisis service, an Emergency Indicator field will appear. Enter whether this was an emergency or not.

Service	
Status	Show <input type="text"/>
Program	Outpatient MH Adult <input type="text"/>
Procedure	Crisis Intervention Services, per 15 mi <input type="text"/> <a href="#">Modifier...</a>
Location	Office <input type="text"/>
Clinician	Clinician, Robert
Mode Of Delivery	Face-to-face <input type="text"/>
Cancel Reason	<input type="text"/>
Evidence Based Practices	<input type="text"/>
Start Date	01/23/2023 <input type="text"/>
Start Time	8:00 AM <input type="text"/>
Travel Time	20 <input type="text"/> Minutes
-----	<input type="text"/> Minutes
Documentation Time	10 <input type="text"/> Minutes
Face to Face Time	60 <input type="text"/> Minutes
Attending	<input type="text"/>
Referring	<input type="text"/>
Emergency Indicator	Yes <input type="text"/>

d



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3. If the status is show, you may now click on the Note tab. Complete the progress note tab. This note type may look different depending on the procedure code you have chosen. Most will include 3 fields: the Problem List section, the Note section, and the Care Plan section.
  - a. If you want to add problems to the problem list, you can do so here. Follow the instructions in **How do I add a problem to the Problem List?**.

**Problem Details** 3

★

Code  Search    Description  Search    🔍 ☆

Start Date:  📅    End Date:  📅    Program:  ▼

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**Problem List** Insert Clear

			SNOMED Description	SNOMED CT Code	ICD 10 Code	Start Date	End Date	Program
✕	<input type="radio"/>	ⓘ	Housing instability due to immi...	1156192009	Z59.811	01/04/2023		Outpatient MH Adult
✕	<input type="radio"/>	ⓘ	Severe food insecurity on Unite...	470951000124105	Z59.41	01/04/2023		Outpatient MH Adult
✕	<input type="radio"/>	ⓘ	Positive screening for depressio...	464481000124106	Z13.31	01/04/2023		Outpatient MH Adult
✕	<input type="radio"/>	ⓘ	Accidental bumping into station...	217896007	W22.09XD	01/11/2023		Outpatient MH Adult



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b. Select which problems you addressed in today's session.

Problems addressed during this session Refresh

**b**

- Housing instability due to imminent risk of homelessness
- Severe food insecurity on United States household food security survey module
- Positive screening for depression on Patient Health Questionnaire 2
- Accidental bumping into stationary object



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- c. Enter your note in the Note section. This should include all your usual clinical information, such as your interventions and the client’s response to the interventions.

**Note**

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

Function: note added

Intervention: note added

Response: note added

Plan: note added



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- d. Enter your plan of care in the Care Plan section. For services that require a treatment plan, this is where the treatment plan is entered. This information will pull forward from the most recent service note in the same program. There may be text templates available for specific treatment plan requirements.

**Care Plan**

Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Include a transition plan if the individual has achieved the goals of the care plan.

Client will be taking walks to destress



## How To Write A Progress Note For A Scheduled Service

- The Billing Diagnosis tab will show you which diagnoses will be pulled onto the billing. You should generally ignore this tab for ongoing services. However, if you need to change the billing order, for example you want this note to focus on the secondary diagnosis, you can re-order the diagnoses to match your service without changing the overarching diagnosis form.

Service	Note	Billing Diagnosis	Warnings	Disposition
Billing Diagnosis				
		1 F25.0 - Schizoaffective disorder, Bipolar type		
<a href="#">Re-Order Diagnosis</a> <a href="#">Refresh Diagnosis</a>				

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5. When you are complete, click Sign.

